THE MEDICAID MANAGEMENT EXCHANGE-MMX

ADMINISTRATIVE NOTES ON MEDICAID MANAGEMENT

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CLEARINGHOUSE

ISSUE #4

Clearer, Simpler Regulations

SIMPLER AND CLEARER REGULATIONS are the result of an intensive Medicaid Bureau effort to rewrite and reorganize Medicaid regulations. The new regulations, effective October 1, 1978, are part of HEW's Project Common Sense, an initiative to make the regulations more understandable to those affected (including State agencies, applicants and beneficiaries, and providers of services), and more useful for program administrators.

No substantive policy changes were made in the regulations during this first phase of the Medicaid recodification project. The regulations will now be systematically and intensively reviewed for possible revisions under phase two of the project.

Region VII Publishes Best Practices

REGION VII'S MEDICAID BUREAU has published a report identifying good management practices in several of the States in the Region. These are practices identified by State Medicaid Management Reviews, and cover all areas of program management.

Copies of the report are available on request to:

William R. Blake, Jr.
Regional Medicaid Director, R VII
Health Care Financing Administration
601 E. 12th Street
Kansas City, MO. 64106

Phone-In Pharmacy Bills

TEN PHARMACIES IN KENTUCKY are now submitting claims via telephone, as part of a pilot project. Using a push-button phone, the pharmacists call a toll-free number to reach a computer located in Frankfort. The caller is then instructed by the "talking" computer to enter his personal code. The computer also tells the caller when the needed claim information has been entered.

The Kentucky Dept. for Human Resources Secretary, Peter Conn, said the Pharmacy Telephone Transmission System (PTTS) should make it both simpler and faster for pharmacists to be paid by the State for prescriptions filled for Medicaid clients. The Department hopes to save processing time and costs as well. The system will be evaluated in late November. If successful, the service will be offered to all 870 pharmacies in the State. Pharmacists will, however, retain a choice on methods of submitting bills.

Arkansas EPSDT

ARKANSAS IS PLANNING to exempt EPSDT recipients from co-payments on drugs. Children referred for screening will be issued a special card containing ID information, a referral date, and an expiration date. Clients will be instructed to give the card to the pharmacist filling the prescription, who will then retain it for audit purposes.

MMIS UPDATE

NEWLY CERTIFIED MMIS STATES are ALABAMA and IDAHO. This brings to 19 the number of States receiving 75% match for MMIS operations. They are:

Alabama	New Hampshire
Arkansas	New Mexico
Georgia	North Carolina
Hawaii	Ohio
Idaho	Oklahoma
Indiana	Texas
Louisiana	Utah
Michigan	Washington St.
Minnesota	Wisconsin
Montana	

Currently, CALIFORNIA, NEBRASKA, VIRGINIA, and the NEW YORK CITY system have been reviewed and are awaiting certification. It is expected that FLORIDA, KANSAS, KENTUCKY, MAINE, MASSACHUSETTS, MISSISSIPPI, NEW JERSEY, NEW YORK (balance of State), NORTH DAKOTA, and VERMONT will apply for certification in FY 1979.

EDSF North Dakota Fiscal Agent

ELECTRONIC DATA SYSTEMS (EDSF) began processing claims for NORTH DAKOTA on September 1, 1978. New claims forms are being used to facilitate processing. It is expected that North Dakota will apply for MMIS certification during FY 1979.

Alaska Amoeba

ALASKA IS INSTALLING AN AMOEBA (Automated Medicaid Overutilization and Erroneous Billing Auditor) to assist in claims processing, with implementation expected to be complete in January. Rather than installing an MMIS, Alaska is automating various components of its present claims processing system. One benefit will be to free up staff, allowing Alaska to be more responsive to changes in Federal requirements.

New York MMIS Update

THE IMPLEMENTATION OF MMIS in NEW YORK is proceeding smoothly. Claims processing in NEW YORK CITY began April 1 for pharmacies, June 1 for inpatient hospitals, and September 1 for labs and dentists. Processing of clinic, outpatient hospital, and physician claims began November 1, 1977. Other provider groups are being phased in through next March 1. For all MMIS provider groups, properly completed claims are being processed within 10 working days. Certification of the operating portion of the system is expected in the near future.

To smooth the implementation of MMIS, Bradford has conducted a successful provider relations and education program that includes training sessions, a speaker's bureau, and an MMIS inquiry hotline. Provider enrollment has increased significantly, with the number of physicians submitting claims to NYC Medicaid increasing from 2,000 before MMIS to the current 9,600.

The State has implemented regulations calling for the submission of claims in NYC within 90 days from date of service. In addition, the State has implemented a uniform hospital billing form, designed for use by all third party payors. This form, expected to ultimately replace all other forms for inpatient billing, was designed by the Health and Hospital Corp. of NYC, the Greater NY Hospital Association, and the NY Dept. of Health.

Recently, New York State released an RFP for an MMIS for the balance of New York State (the 57 upstate counties) and a bidders' conference was held Aug. 28. Closing date for proposals was Oct. 2, with final selection expected mid-to-end November. The two bidding firms were Bradford National and Sanford Associates.

Pennsylvania MMIS

PENNSYLVANIA BEGAN PROCESSING podiatrists' claims July 15 to test its MMIS in the first step toward implementation. Dentists are scheduled to go on-line in December, and physicians in the first half of 1979. The target implementation date for the total system is the end of 1979.

For podiatrists' claims, there is a complete system of edits in place, including eligibility, history, TPL, and other routine edits. The system uses a computerized Medicaid eligibility file containing on-line inquiry capability. In the future, this will be replaced by a Client Information System that will integrate all State assistance eligibility files, including AFDC, Food Stamps and Medicaid.

The MMIS will contain an EPSDT module similar to the EPSDT prototype being developed by MMB's Division of Information Systems. The module will identify children scheduled to be screened, and track EPSDT clients through follow-up and treatment. In addition, Pennsylvania plans to enhance its Third Party Liability (TPL) system.

GAO Audits MMIS

NEITHER THE STATES NOR THE FEDERAL GOVERNMENT are realizing all benefits expected from the MMIS, according to a recent General Accounting Office (GAO) audit. Systems reviewed did not meet all requirements of the law and regulations, and often were incompatible with Medicare information systems. Also, information needed to adequately monitor and contol costs was found lacking by the study.

Single copies of the complete audit (HRD-78-151) are available upon request from: U.S. General Accounting Office, Distribution Section, Room 1518, 441 G Street, N.W., Washington, D.C. 20548.

Georgia Calls MMIS Success

MMIS HAS BEEN A HUGE SUCCESS in GEORGIA, despite past problems with systems implementation, according to the Georgia Dept. of Medical Assistance. Of particular note is the reduction of average claims processing time from 120 to 18 days.

Use of the tape-to-tape format for certain claims has increased processing speed, reduced error and rejection rates, and created major saving in data entry costs. Other management improvements have occured in provider relations, tracking claims status, eligibility certifications, and third party liability.

California Awards MMIS

CALIFORNIA HAS AWARDED Computer Sciences Corporation (CSC) a 5 1/2 year fiscal intermediary contract to process Medicaid claims and operate an MMIS. CSC's bid of $129.6 million was $4 million lower than that of the next bidder, Blue Shield, in the first competitively bid contract for Medicaid claims processing in California. Gregory Thompson, who directed the procurement effort for the California Dept. of Health, said in contrast with the current contract, the State will save from $20 to $30 million a year under the new contract.

The contract is effective Sept. 1, 1978, with this phase-in schedule: drugs, 9 months; LTC, 12 months; inpatient/outpatient hospital, 15 months; and medical, 18 months. The State will continue to process dental claims under a separate contract with planning for the RFP on this currently underway.

Under the new contract, an estimated 175,000 claims will be processed daily, for health services worth about $3 billion yearly. The Computer Company of Richmond, VA is the subcontractor for CSC.

Louisiana Chooses EDSF

ELECTRONIC DATA SYSTEMS FEDERAL CORPORATION (EDSF) was the successful bidder on a two year MMIS/fiscal agent contract in Louisiana, to be effective Jan. 1, 1979. The first year cost is 79 cents per claim, with second year costs to be adjusted by a percentage equal to the changes in the Consumer Price Index. EDSF is also the current fiscal agent in Louisiana, a State that recently received MMIS certification.

Alabama Extends Contract Period

ALABAMA HAS ENACTED LEGISLATION permitting the Medicaid agency to contract with fiscal agents for up to three years. Previously, State law restricted the agency to a one year contract period. The new provision will benefit the State by eliminating a time-consuming annual competitive process and by leading to improved program continuity.

Medi-Cal to Start Program Abuse Index, Requests Help

THE MEDI-CAL AUDIT PROJECT is developing an Abuse-Methods Index as part of an effort to detect and audit providers potentially abusing the Medicaid program. The Index will include information on methods used by medical providers to defraud and abuse medical programs, both public and private. Located in the CALIFORNIA Controller's Office, project staff requests those interested in the project to contribute material to the Index. Material submitted should include details of abusive procedures and methods, rather than names. Material on all provider types is needed.

All material, and questions concerning the project should be addressed to: William H. Welty, Medi-Cal Audit Project, Suite 300, 1507 21st St. Sacramento, Ca. 95814.

Uniform Classification System

HEW HAS ENDORSED a new disease classification system for use in hospitals and related clinical settings. Beginning Jan. 1, 1979, the new system, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) will be required in such HEW financed programs as Medicare, the PSRO program, and the Cooperative Health Statistics System. It is hoped that ICD-9-CM will become a standard, National system, eliminating the difficulties that current competing systems of classification have caused.

The Medicaid Bureau supports this effort, and is encouraging States to implement ICD-9-CM rapidly. A 90% match will be available for implementation in MMIS. Also, HCFA has contracted with the Commission on Professional and Hospital Activities (CPHA) in Ann Arbor to assist in the implementation of the system. Code conversion tables, code grouping tables, and editing aids are available. Inquiries should be directed to CPHA's toll-free number-(800) 521-6210. To order manuals or implementation aids, contact Ms. Gayle Woodcock, ext. 231. To obtain answers to technical questions, contact Ms. B.N. Thomson, ext. 481.

Competitive Procurements Save Costs

AT LEAST SIX STATES have achieved cost savings by switching from sole-source to competitive contracts for fiscal agents, according to estimates made by the MMB and the State of CALIFORNIA. States with reduced costs include: VIRGINIA, saving $337,000 over three years; TENNESSEE, savings $3.1 million over three years; ALABAMA, saving $726,000 on the 1976-1977 yearly contract; and CALIFORNIA, which estimated savings of more than $20 million yearly.

95th Congress Adjourns

THE 95TH CONGRESS ADJOURNED October 15 without passing the majority of Medicaid-related bills under consideration. One bill that passed was the HMO Amendments of 1978, S 2534. Bills that died, and would have to be resubmitted next session include the Talmadge Bill, (Medicare and Medicaid Administrative and Reimbursment Reform Act), the Clinical Laboratory Improvement Act, CHAP, and a proposal (HR 9434) to raise payment ceilings for Guam, the Virgin Islands, and Puerto Rico. In addition, Hospital Cost Containment, National Health Insurance, and Welfare Reform must wait for future sessions.

HMO Amendments

One section of the HMO Amendments of 1978 (S 2534) attempts to prevent recurrence of past abuses in HMO enrollment of Medicaid beneficiaries. Based in part on the Nunn Report that spelled out past abuses that occurred in California, the bill directs the Secretary of HEW to promulgate regulations controlling enrollment practices of HMOs in regard to Medicaid beneficiaries.

In addition, the bill amends Title XIX by extending to State Medicaid employees the conflict of interest provisions applied to Federal employees as contained in Sections 207 and 208 of Title XVIII of the U.S. Code. These sections prohibit acting as an agent or attorney, except for the U.S. Government, on matters connected with present or former duties or official responsibilities, and participating in matters in which the employee or any related party has a financial interest.

Progress Through Partnership

Institute for Medicaid Management

CHAP and HR 9434

Before adjournment, the Senate Finance Committee (Long, D-LA, chmn.) marked up CHAP (S 1392) and HR 9434, combining the two into one bill. The Committee scaled down the House version of CHAP considerably. The members eliminated coverage of low-income pregnant women, and cut mandatory coverage of low-income children to include only those through the age of six. The increased Federal match proposed by the Administration was maintained, rather than the higher match decided on by the House.

Like the House, Senate Finance doubled the FY 1979 payment ceilings for Guam, Puerto Rico, and the Virgin Islands in HR 9434. However, the Committee did not provide for future automatic ceiling increases. Also, Senate Finance called for using the standard matching formulas for PR, GU, and VI, as did the House. The Committee added to the bill a $500,000 ceiling and set a 75% match rate for the Northern Mariana Islands.

The Senate bill would also have: (1) funded a large-scale demonstration project to train and employ welfare recipients as home health aides; and (2) elevated the HCFA Administrator position to presidental appointee status, subject to Senate approval.

Other Bills

The Senate passed the Talmadge Bill in the week before adjournment; the House took no action on these Medicare-Medicaid amendments. In a last minute compromise suggested by Sen. Magnuson (D-WA), the HEW appropriations bill was passed with abortion language identical to last year's. The same language was extended to the Dept. of Defense appropriations bill.

New Medicaid Unit in NC

A NEW DIVISION OF MEDICAL ASSISTANCE, (DMA) with full responsibility for all aspects of the Medicaid program, has been created in NORTH CAROLINA. Formed on July 1, 1978, the new division consolidates the functions formerly spread throughout the Division of Social Services (DSS). Both DMA and DSS are components of the North Carolina Department of Human Resources.

Creation of the new division of more than 100 people was a direct result of a study which concluded Medicaid could be more efficiently managed as an autonomous division with direct fiscal responsibility. Mr. James E. Gibson, Jr., former Deputy Director, has been named Director of the Division.

MMB Shows Commitment to State Management Reviews

AN INCREASING CONCERN with State Management Reviews has been shown by the Medicaid Bureau (MMB). Attendance was heavy at the recent State Assessment Workshop, held in San Antonio September 12-15, with about 115 staff from the MMB Central and Regional Offices, and the Office of Program Integrity attending the training sessions. The workshops on planning and performing management reviews were led primarily by Regional Office personnel.

The reviews, which assess core areas of a State's Medicaid administration, will receive even heavier attention as they enter their third year. Twenty-six reviews are scheduled for FY 1979, as Regions devote more staff to determining how efficiently Medicaid dollars are spent. Each State Medicaid agency will have been reviewed at least once by the end of FY 1979.

California Second Opinion

CALIFORNIA'S LEGISLATURE HAS MANDATED a second opionion program under its Appropriation Act. Medi-Cal is developing a list of 10 procedures for which second opinions will be required, and 24 additional procedures for which second opinions will be optional.

Massachusetts' Drug Costs Increase

IMPLEMENTATION OF FEDERAL EAC listings in MASSACHUSETTS reduced the cost of ingredients by an average of $.32 per prescription. Subsequent pharmacist lobbying of the legislature resulted in the dispensing fee being raised from $2.10 to $2.70, increasing the net cost per prescription $.28.

PERSONNEL

LEONARD D. SCHAEFFER WAS SWORN IN as new Administrator of the Health Care Financing Administration (HCFA) October 30. He is moving over from his position as HEW's Assistant Secretary for Management and Budget. Mr. Schaeffer's previous experience includes positions as: Vice President, Citibank, in NYC; Director, Bureau of the Budget, State of Illinois; and Deputy Director for Management, Illinois Department of Mental Health and Developmental Disabilities.

Mr. Schaeffer replaces Robert A. Derzon, HCFA's first Administrator, who recently resigned. HCFA's Deputy Administrator, William Fullerton, has also resigned, but is staying on temporarily to assist during the transition.

New Single State Agency Heads

Mr. Keith L. Colbo, Montana

New State Medicaid Directors

Mrs. Sharon Marcum, Arkansas
Mr. David D. Williams, Maine

REPORTS FROM STATES INDICATE that efforts to use third party resources are leading to considerable cost savings.

Third Party Liability (TPL) efforts in WASHINGTON saved costs of more than $13 million in FY 1978, according to State estimates. About $12 million was saved through cost avoidance at the front of the system, while post-payment collections netted another $1.1 million. The State has found that their MMIS has helped greatly in identifying TPL resources.

MICHIGAN'S goal for TPL collection and cost avoidance for FY 1979 is $27.5 million, according to State officials. For FY 1978, TPL recoveries totaled $5.8 million, and an estimated $12.3 million was saved through cost avoidance. The ratio of recoveries to savings is expected to be about 15:1. Partial automation of Michigan's TPL system began July 1978, with full automation scheduled for the end of FY 1979.

Michigan has identified 130,000-140,000 Medicaid beneficiaries as having potential TPL resources. This number is expected to increase as the quality of information increases. County intake workers collect the name and number of any insurance policy, which is then printed on the Medicaid ID card for the information of providers.

In addition, Michigan is working with Friends of the Court organizations in five counties to identify through court orders responsible parents with medical insurance. In addition, Friends of the Court is working to assure that those divorce settlements that call for support of children include health insurance.

GEORGIA'S Benefit Recovery Unit increased collections 79% between FY 1977 and FY 1978, with collections from third parties and overpayments to providers rising from $3.1 to $5.6 million. The increase is attributed to following up on claims exceeding $100 when a third party resource or injury by accident was indicated, and to improved identification of TPL at the eligibility determination level.

FLORIDA passed legislation giving the Dept. of Health and Rehabilitation Services authority to recover payments directly from the third party or from recipients receiving third party payments.

ALABAMA'S third party unit has found that many aged Medicaid beneficiaries have other insurance. This is particularly true of the joint Medicaid-Medicare population, where a computer check matched 9,000 aged Medicaid beneficiaries with holders of Blue Cross supplement policies.

The MMB Corrective Action Project (CAP) offers technical assistance to States wishing to install third party benefit recovery systems, Currently, CAP is working on-site in Pennsylvania, Illinois, and Texas on TPL systems.

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UPCOMING
IMM EVENTS

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MANAGING CHANGES IN THE STATE MEDICAID PROGRAM - This mid-year meeting of State Medicaid directors will be held December 1-2 in Atlanta, Ga. Key management and organizational principles that relate to changes in Medicaid administrative and program activities will be discussed. For further information, contact Alicia Coro of the IMM at (202) 245-0734.

HMO Contracting Workshops

A SERIES OF FOUR WORKSHOPS is being sponsored by the Medicaid Bureau, to allow State officials to share their experiences, and to disseminate information and available methodologies on the topic. Subjects to be covered include: setting capitation rates; findings of the Prepaid Health Plan Research and Demonstration Project (PHRED) occuring in California; approaches to HMO marketing; and HMO performance monitoring. Faculty will be drawn from States and the Martin E. Segal Company. The Segal Co. recently completed a guide, HMOs and Medicaid: Approaches to Capitation Contracting, which will be used as a text in the workshops. The workshop schedule is:

States in	Regions I, II 1/30-31/1979	Boston
"	" Regions III, IV VI, VII 2/27-28	Atlanta
"	" Region V 3/27-28	Chicago
"	" Regions VIII-X 5/1-2	Seattle

For further information on the workshops, or for a copy of HMOs and Medicaid, contact: Tony DiNuzzo, Office of State Operations/MMB, Room 4050 HEW South, 330 C Street, S.W., Washington, D.C. 20201, or call him at (202) 245-0361.

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